serves. There are no powers inherent in the office; they must be delegated by the president. Somehow, not only has Cheney been given vast authority by President Bush—including, apparently, the entire intelligence portfolio—but he also pursues his own agenda. The real question is why the president allows this to happen.

Three decades ago we lived through another painful example of a White House exceeding its authority, lying to the American people, breaking the law and shrouding everything it did in secrecy. Watergate wrenched the country, and our constitutional system, like nothing before. We spent years trying to identify and absorb the lessons of this great excess. But here we are again.

Since the Carter administration left office, we have been criticized for many things. Yet I remain enormously proud of what we did in those four years, especially that we told the truth, obeyed the law and kept the peace.

AMERICA'S WOUNDED WARRIORS ACT

Mr. BURR. Mr. President, today I rise to discuss S. 2674, a bill I introduced to improve and modernize the disability system of the Department of Defense and Department of Veterans Affairs so that it meets the needs of both our older generations of veterans and our wounded warriors coming home today.

One of the most sacred trusts we make is the one with our veterans. Their sacrifices, and the sacrifices of their families, are inspiring. The desire to provide these heroes with the benefits and services they need and deserve is certainly something we can all agree on.

With this sacred trust in mind, I recently introduced legislation to ensure veterans have a disability system that we can all be proud of—a system that is updated to reflect the modern day, is consistent, is not overly bureaucratic, and meets the needs of all generations of veterans.

The challenges facing our newer veterans are apparent. Over the past few years, I have met with many young servicemembers, some from my home State of North Carolina, who have suffered devastating injuries while serving in Iraq and Afghanistan. Almost as remarkable as their courage and their can-do attitudes, is their outlook about the future.

These wounded warriors rightfully expect that serious injuries should not prevent them from living productive and fulfilling lives. In fact, many want nothing less than to return to their units, and with modern medicine and technology, many are doing just that.

But for those who are not able to continue serving, like Ted Wade from my home State, they deserve a disability system that meets their needs and expectations. We should be giving them—in a quick, hassle free, and effective way—the benefits and services they need to return to their full and productive lives.

But, the need for an improved system became very clear last year, when news reports detailed how some seriously injured servicemembers at Walter Reed endured a lengthy, hard-to-understand, bureaucratic process to try to get their disability benefits. This left many injured servicemembers and their families frustrated, confused, and disappointed. It left our Nation angry and ashamed.

Let me give you a brief idea of what an injured servicemember may have to go through. Consider a young soldier who is injured in Iraq and is no longer fit for duty because of his injuries. Before he can be discharged from the military, he may go through a lengthy, complex process with the Department of Defense to be assigned a disability rating between 0 percent and 100 percent.

If the rating is high enough—30 percent or more—he will get a lifetime annuity, health care for his entire family, exchange and commissary privileges, and other benefits. If it is below 30 percent, he will get only a lump-sum severance payment. But there have been no bright-line rules on how these ratings are assigned. Each branch of the military has used different procedures, so servicemembers in various branches often receive different ratings even for the same injuries.

After going through that confusing process, the injured soldier may then go through a similar bureaucratic process with the Department of Veterans Affairs to get a VA rating. That rating will determine not only the level of monthly disability compensation he will receive from VA, but eligibility for other benefits and services such as vocational rehabilitation and priority access to VA health care.

As if all of that isn't confusing enough, both DOD and VA assign those disability ratings based on the same VA rating schedule, but the ratings are often different. And, there are complicated rules over how much of the benefits from DOD and VA the veteran may receive at the same time. If those watching today are as confused by that description of the process as I am, imagine what our veterans have to endure.

On top of all that, the rating schedule used by both VA and DOD to determine who gets these critical benefits is completely outdated. This schedule was developed in the early 1900s and about 35 percent of it has not been updated since 1945.

The schedule is also riddled with outdated criteria that do not track with modern medicine. Take for example traumatic arthritis. The rating schedule requires a veteran to show proof of this condition through x-ray evidence. But doctors today would generally diagnose the condition using more modern technology, like an MRI.

Even worse, experts are telling us the schedule is not adequate for rating conditions like post-traumatic stress disorder and traumatic brain injury, which are afflicting so many of our veterans from the war on terror. Also, experts have told us that the schedule does not adequately compensate young, severely disabled veterans; veterans with mental disabilities; and veterans who are unemployable.

So, it's completely understandable why so many veterans are frustrated and confused by this system. The question is:

How do we fix it?

To help answer that question, two distinguished commissions issued reports last year laying out the problems with the system and giving us a road map to a modern, more consistent, and simpler system. One commission, the President's Commission on Care for America's Returning Wounded Warriors, was chaired by former Senator Bob Dole and former Secretary Donna Shalala. The other, the Veterans' Disability Benefits Commission, was chaired by General James Terry Scott.

Here are just a few examples of what these commissions found:

> Despite their disability systems' different intents, processes, and outcomes, DOD and VA use the same outdated rating schedule . . . . [which] has not been completely revised since 1945.
>
> [T]he policies and procedures used by VA and DOD are not consistent and the resulting dual systems are not in the best interest of the injured servicemember nor the nation.
>
> The purpose of the current veterans disability compensation program . . . is to compensate for average impairment in earning capacity . . . This is an unduly restrictive rationale for the program and is inconsistent with current models of disability.
>
> The goal of disability benefits should be rehabilitation and reintegration into civilian life'' but that goal ''is not being met.

These two commissions strongly recommended that we need to: get rid of the overlapping, confusing roles of VA and DOD in the disability rating process; completely update the VA disability rating schedule; compensate veterans for any loss of quality of life, while also compensating them for any loss in their earnings capacity; and place more emphasis on the treatment and rehabilitation of injured veterans.

As the Dole-Shalala Commission cautioned, ''We don't recommend merely patching the system, as has been done in the past. Instead, the experiences of these young men and women have highlighted the need for fundamental changes.''

What's interesting to note here is that similar changes to the system were recommended in 1956 by a commission led by General Omar Bradley. Back in the 1950s, the Bradley Commission wrote in its report: ''Our philosophy of veterans' benefits must . . . be modernized and the whole structure of traditional veterans' programs brought up to date.'' If my math is right that was over 50 years ago. Clearly, we are long overdue for some improvements.

I believe the bill I introduced will start us on the right path to making this system more straight-forward, consistent, and modern. Let me give you an idea of what America's Wounded Warriors Act would do.

First, the bill would simplify the DOD process and make it more consistent. Any servicemember found unfit for duty—regardless of the severity of the disability—would receive a lifetime annuity based on rank and years of service and would receive other retirement benefits, such as commissary and exchange privileges. Eligibility for TRICARE would be determined by Congress or DOD, after further studies on that issue.

These changes would get DOD out of the business of assigning disability ratings, ending the duplicative system that now makes injured veterans get rated by both DOD and VA. It would also create a bright line rule on what benefits a medically discharged servicemember would receive. Different branches of the military would no longer provide different levels of benefits to servicemembers with the same injuries.

Under my bill, veterans would receive both their entire DOD annuity plus any VA disability benefits they are eligible for. This would put an end to the confusing practice of offsetting some DOD and VA benefits.

This bill would also help modernize the VA disability system. The VA's outdated disability rating schedule would be entirely replaced by a new schedule that is based on modern science and medicine. It will also take into account the impact that a disability has on both a veteran's average loss of earning capacity and loss of quality of life. As we now know, quality of life—time spent with family, community and nonwork activities—is also affected by disability. Shouldn't our disability system reflect the impact service-related disabilities have on those important aspects of life, too?

Also, this bill would provide more emphasis on treatment and rehabilitation. Veterans discharged from service because of disability would be eligible for transition payments, either during the three month period following their separation or during a period of rehabilitation. These payments would help cover family living expenses, so an injured veteran would be better able to focus on rehabilitation, training, and getting back into the workforce. These are commonsense options and solutions for today's veterans living in the modern world.

Lastly, I want all veterans, whether having served in World War II, Vietnam, or Afghanistan, to have access to an improved system. My bill does not distinguish between combat and noncombat injuries; does not leave the outdated rating schedule in place; and does not prevent veterans of any generation from choosing to join the new, improved system. Also, as recommended by veterans' organizations, my efforts were guided by the work of both the Dole-Shalala Commission and the Veterans' Disability Benefits Commission.

How will we actually accomplish the goals of making the system simpler, consistent and more modern? Under this bill, the Department of Veterans Affairs would conduct a series of studies and would send to Congress a proposal outlining a new rating schedule and the amount and duration of transition payments. To make sure these recommendations don't get put on a shelf to collect dust—as has happened in the past—the entire VA proposal would be subject to an up-or-down vote by Congress.

If these changes are enacted, it would eliminate the confusion and delay now caused by the overlapping VA and DOD functions and put a greater emphasis on the recovery of our wounded servicemembers. It would update the rating system to take into account modern concepts of disability and make sure that veterans are compensated for any loss in their quality of life.

As a final note, I want to acknowledge that reforming the disability system may require a large, upfront cost. But, if we do it right, we will be making a real investment in the future of our nation's veterans. Given the character of the men and women of our Armed Forces, this investment will come with little risk and great reward.

We cannot put this off for another 50 years and hope another generation will fix the disability system later. We have young men and women returning home from war with devastating injuries that most of us could not fathom enduring, let alone at such young ages.

The sad truth is that, even though the disability system was already outdated more than five decades ago, Congress and past administrations have not made the necessary changes to keep pace with modern society, a changing economy, and new attitudes towards disability. I believe I have an idea why: This is really hard stuff. This is a complicated system and it is often easier to use band-aids and quick fixes to get us through times of crisis. But, the Walter Reed stories showed all of us last year that wounded warriors—those injured while fighting in Iraq and Afghanistan—are the ones who pay the price for our inaction. And every day we continue to wait is another day they continue to pay that price. They deserve better.

We need to listen to the wake-up call that the Walter Reed stories sent all of us. We must act now, and that is why I have introduced a bill that will update the system to meet the needs and expectations of today's veterans and does not leave tomorrow's veterans with a system that was already outdated before they were even born. Our veterans deserve a system that is more straightforward, up-to-date, and consistent and that is open to all.

Mr. President, I urge my colleagues to remember the ''call to action'' we received last year when serious problems were publicly exposed at Walter Reed, and I ask them to join me in improving the lives of our veterans.

RETIREMENT OF DR. MICHAEL DAVID FREED

Mr. KENNEDY. Mr. President, I welcome this opportunity to pay tribute on the occasion of his retirement to Dr. Michael David Freed of Children's Hospital Boston for his service to the hospital and the thousands of children and young adults from Massachusetts and beyond who have benefited from his care.

Dr. Freed has had a long and distinguished career at the hospital and Harvard Medical School, beginning in 1970, when he arrived to complete his fellowship training. At Children's Hospital, he rose to become senior associate in cardiology in 1976 and chief of the Division of Inpatient Cardiology in 1996.

Dr. Freed is a physician's physician. His commitment to providing the best possible care for children with heart disease is unwavering. He has used his breadth and depth of knowledge, his clarity of thought, his empathy, and his sense of humor to train more than 200 pediatric cardiology fellows and innumerable pediatric residents in the fundamentals of congenital heart disease. As a member of the Sub-board of Pediatric Cardiology, he ensured the highest quality of care by setting standards for board certification for young pediatric cardiologists.

At Children's Hospital, Dr. Freed has chaired or served on more than two dozen committees, projects, and task forces, ranging from quality improvement and patient care to graduate medical education and governance. His contributions extend well beyond Boston. He has served on the executive committees of all three major national organizations in his field—the American Heart Association, the American Academy of Pediatrics, and the American College of Cardiology, where he currently serves on the board of trustees. He is also a member of editorial boards in the field of cardiology, and regularly has been included on lists of ''top physicians'' ranging from the book ''Best Doctors in America'' to Good Housekeeping and Boston Magazine. He is consulted by other pediatric cardiologists from around the world who seek his opinion on the care of their patients.

Dr. Freed has also written extensively in the field of pediatric cardiology and cardiac surgery and is particularly recognized for his work in the newborn physiology of congenital heart disease, infective endocarditis, and valvular heart disease. He has authored more than 60 original articles, contributed more than 40 reviews, chapters, and editorials, and developed more than 25 clinical communications and instructive CD ROMs. His leadership in establishing clinical practice guidelines for early postoperative management of children in Boston undergoing open-heart surgery was a model for the development of such guidelines nationally. In addition, he has been a member of national working groups to develop guidelines on optimal care of individuals with heart disease.